

DATE: _____

APPOINTMENT REQUEST FORM

Please take a few moments to complete the following appointment request form. The purpose of the information provided is to help us understand your concerns and treatment needs. We will use this to see if there is a specific provider with expertise to work with you or your child. We respond to all requests as quickly as possible, but it may take up to a week in some cases. If we are unable to provide you with services, we will try to provide community referrals but also encourage you to talk with your primary care doctor and/or current mental health provider.

Patient Name: _____ Date of Birth: _____ Age: _____

Parent Name: _____ Parent Name: _____

Parent's relationship to each other: Married → Divorced → Domestic Partnership → Never Married →

Address: _____

Phone: _____ Email: _____

Patient's School or Employment: _____ Grade: _____

How did you learn about our Clinic/Provider: _____ Name of Primary Care Physician: _____

Insurance Coverage? Yes: No: If YES, Insurance Plan Name: _____ Member ID: _____

Most of our Clinic's providers are currently contracted with many BUT not all insurance plans associated with PREMERA BLUECROSS and REGENCE BLUESHIELD (see "INSURANCE EXCLUSIONS" below). We advise you to phone your insurance company directly regarding coverage with our Clinic (Tax ID 91-1393485).

INSURANCE EXCLUSIONS:

- (1) Our Providers are NOT contracted with MAGELLAN or BEACON HEALTH (formerly VALUE OPTIONS); therefore payment would be required at the time of each appointment. Please **phone** your insurance company directly to find out if the Behavioral Mental Health coverage on your insurance policy is subcontracted out to MAGELLAN or BEACON HEALTH; and
- (2) Dr. Melyssa Higgins is NOT contracted with any insurance company
- (3) Dr. Samuel Wayne Duncan is NOT contracted with REGENCE BLUESHIELD or its affiliates effective April 1, 2017.

Which of the following treatments are you looking for:

Diagnostic Assessment	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Maybe: <input type="checkbox"/>
Educational Evaluation	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Maybe: <input type="checkbox"/>
Psychotherapy	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Maybe: <input type="checkbox"/>
Medication Management	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Maybe: <input type="checkbox"/>

Is there a specific provider at ABCD that you want to schedule with? Yes: No:

If YES, which provider: _____

If that provider is not available, would you like to see if there is another provider able to see you or your child: Yes: No:

Please indicate all concerns below:

<input type="checkbox"/> ← Attention/ADHD	<input type="checkbox"/> ← Enuresis/encopresis	<input type="checkbox"/> ← Eating	<input type="checkbox"/> ← Aggression
<input type="checkbox"/> ← Learning/educational	<input type="checkbox"/> ← Unusual thoughts	<input type="checkbox"/> ← Anxiety	<input type="checkbox"/> ← Substance abuse
<input type="checkbox"/> ← Depression/mood	<input type="checkbox"/> ← Bipolar disorder	<input type="checkbox"/> ← Suicide/self-harm behaviors	<input type="checkbox"/> ← OCD
<input type="checkbox"/> ← Other (please explain) → _____			

Please provide a brief description below of your concern(s):

Has there been previous treatment with a mental health specialist including psychiatric emergency services or hospitalization? Yes No

If YES, who did you see and when were you in treatment? _____

OFFICE USE ONLY:

TP	MH	JT	MD	AR	SWD	BN	CM
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NOTE: